STATE OF MICHIGAN

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXXX
Petitioner

v **File No. 121226-001**

American Republic Insurance Company
Respondent

Issued and entered
this 17TH day of October 2011
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On May 5, 2011, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* On May 12, 2011, after a preliminary review of the material submitted, the Commissioner accepted the case for external review.

The Commissioner immediately notified American Republic Insurance Company (ARIC) of the external review and requested the information it used to make its final adverse determination. The information was received on May 6, 2011.

The case involves medical issues so the Commissioner assigned the matter to an independent review organization which completed its review and sent its recommendation to the Commissioner on May 26, 2011.

II. FACTUAL BACKGROUND

The Petitioner is covered under an individual health care plan that is underwritten by ARIC. Her benefits are defined in ARIC's "Health Insurance Policy/Certificate" (the policy). The coverage was effective on September 1, 2010.

On November 23, 2010, the Petitioner had a Pap test. The laboratory report indicated a "high grade squamous intraepithelial lesion" (HGSIL) and on January 7, 2011, the Petitioner had a colposcopy, a procedure to examine the cervix, vagina, and vulva for signs of disease.

ARIC denied coverage for the November 2010 office visit, Pap test and the colposcopy procedure on the basis that they were services related to a preexisting condition. The Petitioner appealed the denials through ARIC's internal grievance process. ARIC upheld its denial and issued a final adverse determination on March 24, 2011.

III. ISSUE

Did ARIC correctly deny coverage for the services the Petitioner received on November 23, 2010, and January 7, 2011?

IV. ANALYSIS

Petitioner's Argument

On July 30, 2010, during her annual physical examination, the Petitioner had a Pap test. Her primary care physician received the test report on August 13, 2010, and it revealed the presence of "atypical squamous cells" in the cervix. The Petitioner states her previous Pap tests had been unremarkable. She also states that she scheduled the examination in July 2010 because she wanted to complete it before she sought new insurance coverage.[1]

On November 23, 2010, after her coverage with ARIC was in effect, the Petitioner's primary care physician performed another Pap test that confirmed the HGSIL. The colposcopy was then performed in January 2011.

The Petitioner states she did not know that she had a preexisting condition. In a letter that accompanied her request for an external review she wrote:

> My medical coverage with American Republic was applied for on August 5, 2010. The routine physical (billed to another insurance carrier that we were with prior to American Republic) that showed abnormal lab work, was not completed until August 12th, and returned to my Dr. until August 13th, 2010. All previous lab reports were normal, and I did not have or display any systems or receive any treatment 6 months prior to issue date of coverage with American Republic. This is their basis for denial of benefits.

1 The Petitioner's insurance carrier at the time was in rehabilitation.

The Petitioner argues that the treatment in November 2010 and January 2011 was not for a preexisting condition because she had no knowledge of any abnormality nor any symptoms until after August 5, 2010, the date she completed her application for coverage with ARIC.

Respondent's Argument

ARIC stated the services in November 2010 and January 2011 were for a preexisting condition and therefore not covered under the terms of the policy. The policy contains the following provision in Section III, under "General Exclusions and Limitations" (p. 1):

> This Certificate does not cover any of the following expenses or charges:
>
> * * *
>
> 4. Preexisting Conditions are not covered during the first 12 months. After 12 months, benefits are payable unless specifically excluded from coverage. Conditions fully disclosed on the Application and not excluded from coverage by name or specific description are covered, subject to the provisions of this Certificate.

The policy defines "preexisting condition" in Section I (p. 9):

> **Preexisting Condition**: A condition:
>
> 1. For which medical advice was given or Treatment was recommended by a Provider or received from a Provider within a 6-month period prior to the Issue Date of coverage for that Covered Person; or
> 2. Which produced symptoms within a 6-month period prior to the Issue Date of Coverage for that Covered Person.

In its March 24, 2011, final adverse determination, ARIC listed diagnosis and procedure codes to show that the denied services related to a preexisting condition.

Commissioner's Review

The Michigan Insurance Code permits a health insurer to include a preexisting condition limitation in an individual policy or certificate, but it must conform to Section 3406f [2] of the Code:

> (1) An insurer may exclude or limit coverage for a condition as follows:
>
> (a) For an individual covered under an individual policy or certificate or any other policy or certificate not covered under subdivision (b) or (c),

2 MCL 500.3406f.

> only if the exclusion or limitation relates to a condition for which medical advice, diagnosis, care, or treatment was recommended or received within 6 months before enrollment and the exclusion or limitation does not extend for more than 12 months after the effective date of the policy or certificate.

ARIC's preexisting condition definition (quoted in Respondent's argument above) contains two sections. While the first section generally comports with Section 3406f, the second section does not: symptoms alone, without objective "medical advice, diagnosis, care, or treatment," do not establish a preexisting condition. Because the policy's preexisting condition definition is more restrictive than the statutory provision, the Commissioner will rely on the statutory provision in Section 3406f to decide this case.

The Commissioner concludes that the services the Petitioner received in November 2010 and January 2011 were for a preexisting condition and therefore are excluded from coverage under the terms of the policy.

Because a medical issue was involved, the Commissioner asked an independent review organization (IRO) to examine this case and determine if the services the Petitioner received were for a preexisting condition. See MCL 550.1911(6). The IRO reviewer is an actively practicing physician who is certified by the American Board of Obstetrics and Gynecology. The IRO reviewer concluded, "It is the determination of this reviewer that the services performed on November 23, 2010, and January 7, 2011, were not related to a preexisting condition." The IRO reviewer's report contained the following conclusion:

> Thus the question is whether or not the [Petitioner] was aware of the abnormal Pap smear or had any symptoms of cervical dysplasia six (6) months prior to September 1, 2010 when her new insurance became effective.
>
> The physician who reviewed the Pap smear electronically signed that she had reviewed the Pap smear on August 30, 2010 at 1615 hours. This is evidence that it is unlikely that the [Petitioner] knew that her pap smear was abnormal prior to the start date of her new insurance on September 1, 2010. Thus it does not fall under the pre-existing condition clause as stated by her Insurance Certificate. Cervical dysplasia is typically asymptomatic, thus it would be highly unlikely that the [Petitioner] knew she had this issue.

The Commissioner rejects the IRO reviewer's conclusion and, as required by Section 11(16)(b)[3] of the Patient's Right to Independent Review Act, explains why he "did not follow the assigned independent review organization's recommendation."

3 MCL 550.1911(16)(b).

It was the IRO reviewer's mistaken belief that knowledge of the condition by the Petitioner was required to invoke the preexisting condition limitation. However, such knowledge is not required by either Section 3406f or the policy. The only nexus that needs to be shown is that any excluded services were related to "a condition for which medical advice, diagnosis, care, or treatment was recommended or received within 6 months before enrollment. . . ." The Commissioner believes that nexus has been shown in this case.

In July 2010, the Petitioner had a Pap test. The test result was abnormal; it revealed the presence of atypical squamous cells in her cervix. The laboratory report also reported that "a high grade squamous intraepithelial lesion [*HGSIL*] cannot be excluded." That Pap test falls within the meaning of the term "medical advice, diagnosis, care, or treatment" and it was performed in the six month period before the Petitioner's coverage with ARIC was in effect. It established that there was a preexisting condition related to the Petitioner's cervix.

On November 23, 2010, the Petitioner was seen by her primary care physician. The office notes from that visit state:

> **Chief Complaint/Reason for visit:**
>
> This 35 year old female presents with abnormal pap and would like to consider alt to oc.

Thus, the reason for the November 2010 visit was follow up care for a condition that existed immediately before her coverage with ARIC was effective.

Because of the abnormal results from the test of July 23, 2010, the Petitioner had another Pap test on November 23, 2010. That test revealed the HGSIL and the test report suggested that a colposcopy be considered. The colposcopy was performed in January 2011.

The record in this case shows a continuity of care that is related to the Pap test in July 2010. As the IRO report explained:

> The standard of care for treatment of a patient such as the [Petitioner] is that a screening pap smear would be performed; if the results were abnormal, proceed to colposcopy with biopsies. If the biopsy confirms CIN3 [*cervical intraepithelial neoplasia 3*], an excisional procedure would be performed.

The Commissioner concludes and finds that the services the Petitioner had on November 23, 2010, and January 7, 2011, were related to a condition for which she had medical advice, diagnosis, care, or treatment within six months before she enrolled with ARIC and are therefore excluded from coverage under the terms of the policy.

V. ORDER

The Commissioner upholds American Republic Insurance Company's final adverse determination of March 24, 2011. ARIC is not required to cover the Petitioner's services received on November 23, 2010, and January 7, 2011.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than 60 days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.

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R. Kevin Clinton
Commissioner